

**MONTANA DEPARTMENT OF ENVIRONMENTAL QUALITY
PERMITTING AND COMPLIANCE DIVISION
WASTE MANAGEMENT SECTION
PO BOX 200901
HELENA, MT 59620-0901
Phone: (406) 444-5300
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SOLID WASTE MANAGEMENT SYSTEM LICENSE RENEWAL APPLICATION INFECTIOUS WASTE FOR JULY 1, 2005 - JUNE 30, 2006

I. **FACILITY LICENSE NUMBER** _____ **TAX ID NUMBER** _____

II. **NAME OF FACILITY** _____

III. **FACILITY LOCATION**

Street or Route Number (DO NOT USE P.O. BOX)

City State Zip County

IV. **MAILING ADDRESS**

Street or P.O. Box

City State Zip

V. **NAME OF LICENSEE** _____

VI. **CONTACT PERSON** (Person who may be contacted about the operations of the facility, information contained in this report, and to whom inspection reports should be sent.)

Name _____

VII. **CONTACT INFORMATION**

(Work) _____ (Cell Phone) _____

(Fax) _____ (E-mail) _____

VIII. **MAILING ADDRESS OF CONTACT PERSON**

Street or P.O. Box

City

State

Zip

IX. SYSTEM CAPACITY

A. NUMBER OF FACILITIES (Enter number of facilities you operate under the Facility License Number in Section II) _____

B. **SERVICE AREA** (List all areas served by your facility or system)_____

C. **POPULATION OF SERVICE AREA**_____

D. **ANNUAL TONNAGE BASED ON SCALE RECORDS FROM JANUARY 1 THROUGH DECEMBER 31, 2004**_____Tons

_____ #Compacted Cubic Yards # Cubic Yards x 700 ÷ 2000 = _____Tons
e.g. packer truck

_____ #Uncompacted Cubic Yards # Cubic Yards x 300 ÷ 2000 = _____Tons

_____ #Gallons (x 8 lbs.) ÷ 2000 = _____Tons

Provide copies of the waste measurement records (monthly summaries acceptable).

X. IMPORTED (OUT-OF-STATE) SOLID WASTE

Does your disposal facility accept wastes generated outside of Montana? Yes () No ()

What is the total annual tonnage of out-of-state waste accepted? _____

Where was the out-of-state waste generated?

City

State

County

City

State

County

City

State

County

City

State

County

Population of the out-of-state area(s) served? _____

XI QUESTIONNAIRE (Answers provide information on the status of waste handling in the state.)

A. How do you assess fees for disposal of infectious waste? (Check methods that apply)

1. Tipping fee at the facility

\$_____/ton

\$_____/cubic yard

And/or

2. Other (describe)_____

B. Has the design capacity or operating plan of your facility changed in the last five- (5) years?
Yes () No ()

C. How many employees (full time equivalent) work in your solid waste program? _____
How many hours of safety training did they receive last year? _____
Hazardous waste training? _____
Solid waste operators training? _____

D. The Department is periodically contacted by research organizations, sales personnel, and members of the general public requesting mailing lists for Montana Solid Waste Facilities. State law prohibits the Department from providing a mailing list to non-governmental individuals without the operator's permission. **Do you want your facility name released for use on mailing lists.** Yes () No ()

XII. CERTIFICATION (An authorized representative of the solid waste system must sign and date the certification.)

I, the undersigned, hereby certify that the foregoing information is true and correct to the best of my knowledge and belief.

Authorized Signature:_____

Print Name Here:_____

Title:_____ **Date:**_____

In order to provide meaningful training for facility operators, the department needs to know what training you as operators feel is most needed and appropriate for the personnel at your facility.

Please list your top three training priorities for the next two to three years.

1. _____

2. _____

3. _____

Please provide any additional comments or suggestions regarding Departmental training for facility operators.
